

Beginning Billing Workshop

UB-04

Colorado Medicaid
2015



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Department of Health Care
Policy & Financing



Centers for
Medicare &
Medicaid
Services



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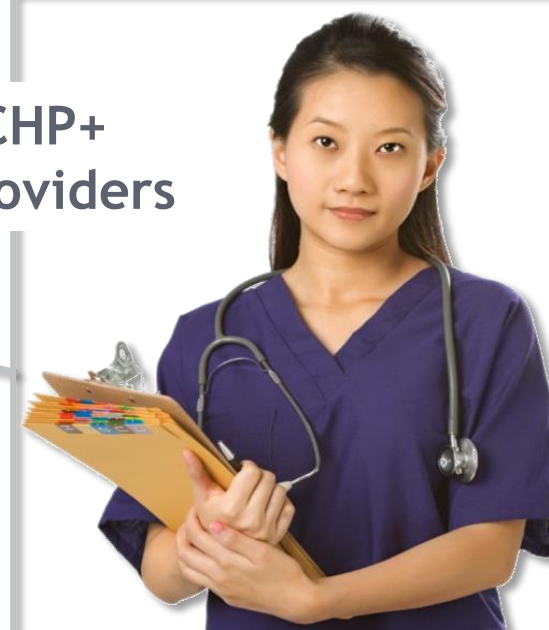


Medicaid



Xerox State
Healthcare

Medicaid/CHP+
Medical Providers



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Training Objectives

- Billing Pre-Requisites
 - National Provider Identifier (NPI)
 - What it is and how to obtain one
 - Eligibility
 - How to verify
 - Know the different types
- Billing Basics
 - How to ensure your claims are timely
 - When to use the UB-04 paper claim form
 - How to bill when other payers are involved



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What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
 - Regardless of job/location changes



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What is an NPI? (cont.)

- How to Obtain & Learn Additional Information:
 - CMS web page (paper copy)-
 - www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html?redirect=/nationalprovidentstand/
 - National Plan and Provider Enumeration System (NPPES)-
 - www.nppes.cms.hhs.gov
 - Enumerator-
 - 1-800-456-3203
 - 1-800-692-2326 TTY



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Department Website

The screenshot shows the website <https://www.colorado.gov/hcpf>. A purple circle with the number '1' and an arrow points to the address bar. A purple circle with the number '2' and an arrow points to the 'For Our Providers' link in the navigation menu. The website header includes the Colorado state logo and the text 'Colorado The Official Web Portal'. The main content area features a navigation bar with links: Home, For Our Members, For Our Providers, and For Our Stakeholders. Below the navigation bar, a banner states: 'We administer Medicaid, Child Health Plan Plus, and other health care programs for Coloradans who qualify.' The main content area is divided into four columns: 'Explore Benefits' (with a magnifying glass icon), 'Apply Now' (with a checkmark icon), 'Find Doctors' (with a group of people icon), and 'Get Help' (with an information icon). At the bottom, there are two promotional boxes: 'Feeling Sick?' with a nurse icon and the text 'For medical advice, call the Nurse Line: 800-283-3221', and 'Get Covered. Stay Healthy.' with an umbrella icon and the text 'colorado.gov/health'.

1

www.colorado.gov/hcpf

2

For Our Providers



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Provider Home Page

Find what
you need
here

Contains important
information
regarding Colorado
Medicaid & other
topics of interest to
providers & billing
professionals



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Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls **providers** into the Colorado Medical Assistance Program, not members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

- Additional information for provider enrollment and revalidation is located at the Provider Resources website

Attending Versus Billing

Attending Provider

Individual that provides services to a Medicaid member



Billing Provider

Entity being reimbursed for service



Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:



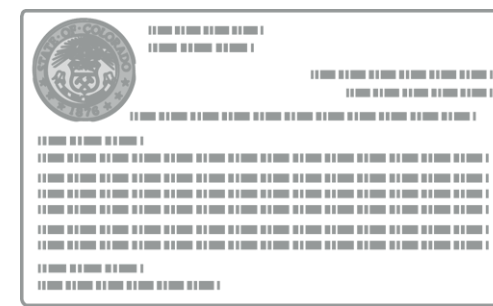
**Colorado Medical
Assistance Web Portal**



**Fax Back
1-800-493-0920**



**CMERS/AVRS
1-800-237-0757**



**Medicaid ID Card
with Switch Vendor**

Eligibility Response Information

Eligibility
Dates

Co-Pay
Information

Third Party
Liability
(TPL)

Prepaid
Health Plan

Medicare

Special
Eligibility

BHO

Guarantee
Number

Eligibility Request Response (271)

[Print](#) [Return To Eligibility Inquiry](#)

Eligibility Request

Provider ID: National Pro
From DOS: Through D
Client Detail
State ID: DOB:
Last Name: First Name

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/20

Contact Information for Questions on Res
Provider Relations Number: 800-237-075

Requesting Provider
Provider ID:
Name:

Client Details
Name:
State ID:

Client Eligibility Details

Eligibility Status: **Eligible**
Eligibility Benefit Date:
04/06/2011 - 04/06/2011
Guarantee Number: **111400000000**
Coverage Name: Medicaid

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date:
04/06/2011 - 04/06/2011
Messages:

MHPROV Services

Provider Name:
COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number:
800-804-5008

Information appears in sections:

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

Successful inquiry notes a Guarantee Number:

- Print copy of response for member's file when necessary

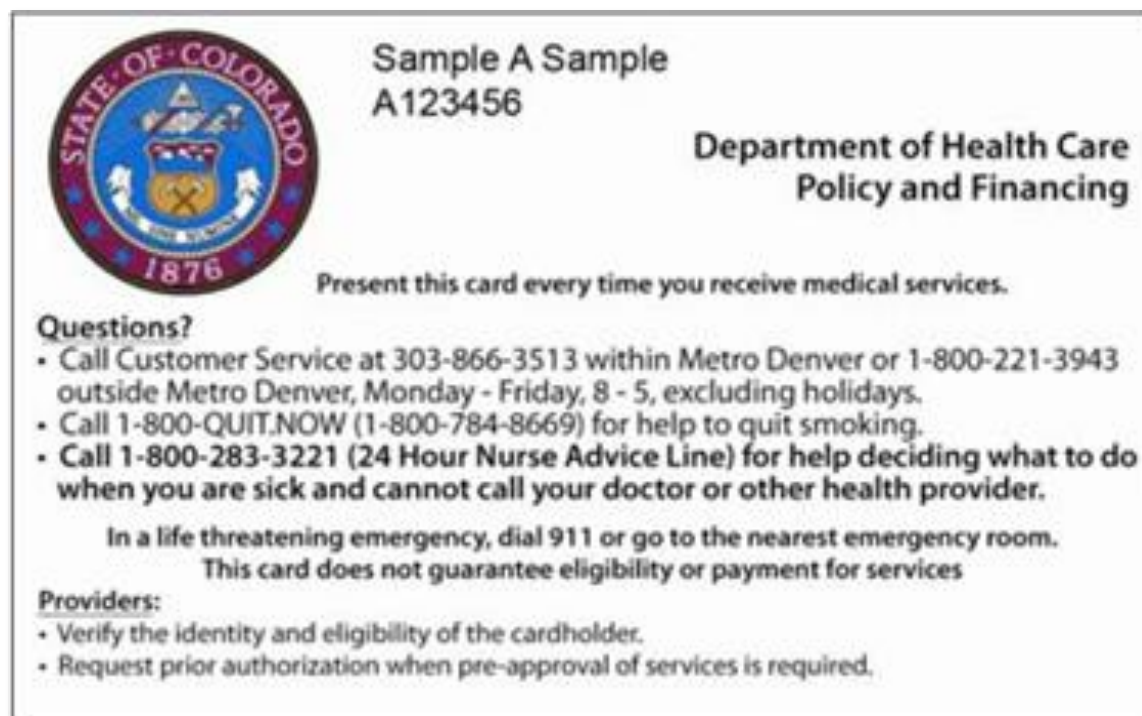
Reminder:

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours



Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility



Eligibility Types

- Most members = Regular Colorado Medicaid benefits
- Some members = different eligibility type
 - Modified Medical Programs
 - Non-Citizens
 - Presumptive Eligibility
- Some members = additional benefits
 - Managed Care
 - Medicare
 - Third Party Insurance

Eligibility Types

Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is \$300
- Does not cover:
 - Long term care services
 - Home and Community Based Services (HCBS)
 - Inpatient, psych or nursing facility services

Eligibility Types

Non-Citizens

- Only covered for admit types:
 - Emergency = 1
 - Trauma = 5
- Emergency services (must be certified in writing by provider)
 - Member health in serious jeopardy
 - Seriously impaired bodily function
 - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

What Defines an “Emergency”?

- Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
 - Active labor & delivery
 - Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
 - Placing health in serious jeopardy
 - Serious impairment to bodily functions
 - Dysfunction of any bodily organ or part

Eligibility Types

Presumptive Eligibility

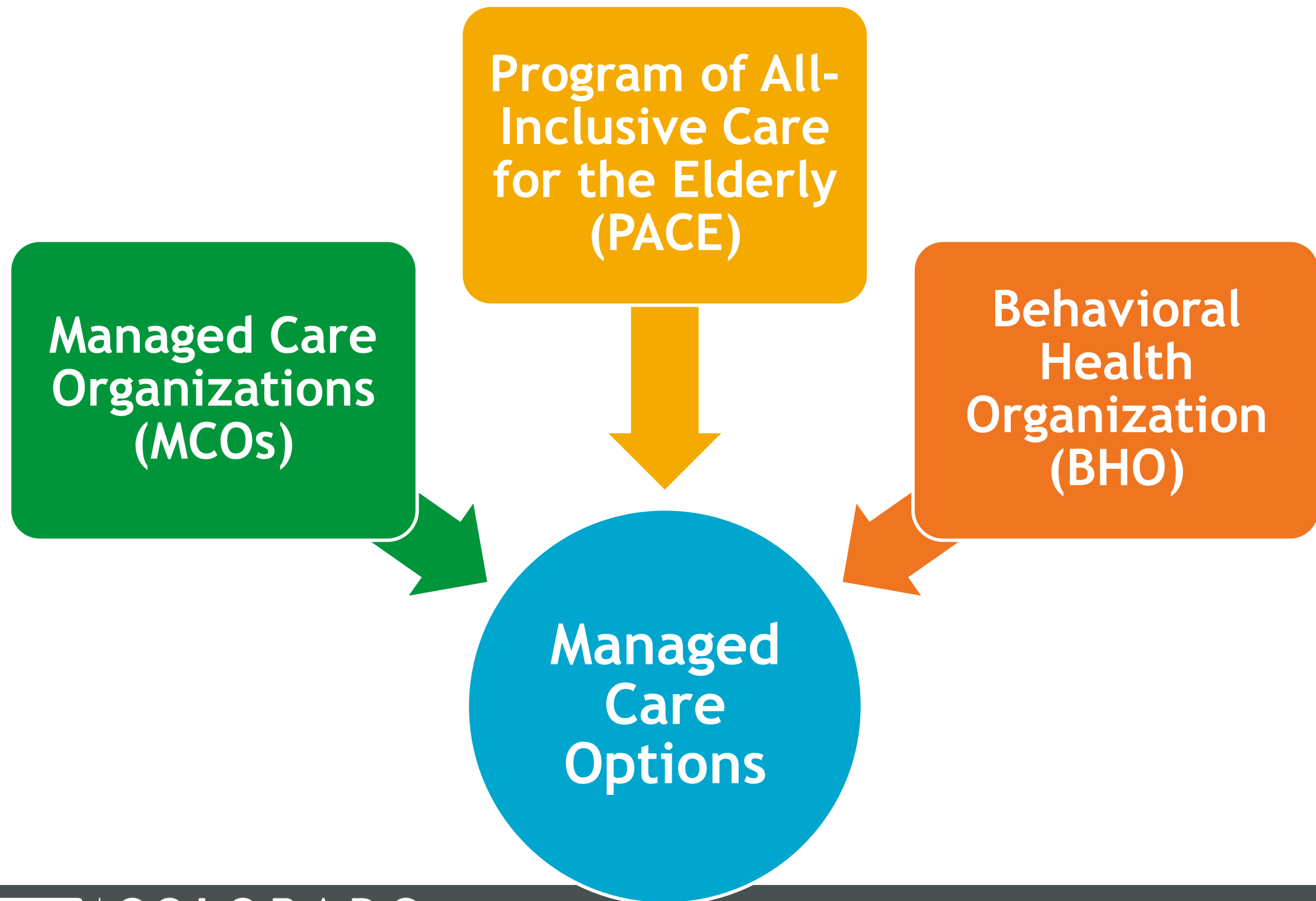
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
 - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
 - Pregnant women
 - Covers DME and other outpatient services
 - Children ages 18 and under
 - Covers all Medicaid covered services
 - Labor / Delivery
- CHP+ Presumptive Eligibility
 - Covers all CHP+ covered services, except dental

Eligibility Types

Presumptive Eligibility (cont.)

- Verify Medicaid Presumptive Eligibility through:
 - Web Portal
 - Faxback
 - CMERS
 - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
 - Submit to the Fiscal Agent
 - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
 - Colorado Access- 1-888-214-1101

Managed Care Options



Managed Care Options

Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
 - MCO benefits exhausted
 - Bill on paper with copy of MCO denial
 - Service is not a benefit of the MCO
 - Bill directly to the fiscal agent
 - MCO not displayed on the eligibility verification
 - Bill on paper with copy of the eligibility print-out

Managed Care Options

Behavioral Health Organization (BHO)

- Community Mental Health Services Program
 - State divided into 5 service areas
 - Each area managed by a specific BHO
 - Colorado Medical Assistance Program Providers
 - Contact BHO in your area to become a Mental Health Program Provider

Medicare

- Medicare members may have:
 - Part A only- covers Institutional Services
 - Hospital Insurance
 - Part B only- covers Professional Services
 - Medical Insurance
 - Part A and B- covers both services
 - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other Third Party Liability (TPL)
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
 - QMB Medicaid (QMB+)- members also receive Medicaid benefits
 - QMB Only- members do not receive Medicaid benefits
 - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always payer of last resort
 - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
 - Submission to Medicare prior to Colorado Medical Assistance Program
 - Medicare denials(s) for six years

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

- Charge = \$500
- Program allowable = \$400
- TPL payment = \$300
- Program allowable - TPL payment = LOP

$$\begin{array}{r} \$400.00 \\ - \$300.00 \\ = \$100.00 \end{array}$$

Commercial Insurance

- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
 - Bill member difference or commercial co-payments
 - Place lien against members right to recover
 - Bill at-fault party's insurance

Co-Payment Exempt Members



**Nursing Facility
Residents**



Children



**Pregnant
Women**

Co-Payment Facts

- Auto-deducted during claims processing
 - Do not deduct from charges billed on claim
- A provider may not deny services to an individual when such members are unable to immediately pay the co-payment amount. However, the member remains liable for the co-payment at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- Services that do not require co-pay:
 - Dental
 - Home Health
 - HCBS
 - Transportation
 - Emergency Services
 - Family Planning Services
 - Behavioral Health Services

Specialty Co-payments

Practitioner, Optometrist,
Speech Therapy, RHC / FQHC

\$2.00

DME / Supply

\$1.00 per date of service

Outpatient

\$3.00

Inpatient

\$10.00 per covered day or 50% of average allowable daily rate- whichever is less

Psych Services

.50 per unit of service, 1 unit = 15 minutes

Billing Overview

Record
Retention

Claim
submission

Prior
Authorization
Requests
(PARs)

Timely filing

Extensions for
timely filing

Record Retention

- Providers must:
 - Maintain records for at least 6 years
 - Longer if required by:
 - Regulation
 - Specific contract between provider & Colorado Medical Assistance Program
 - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
 - Substantiate submitted claim information
 - Be signed & dated by person ordering & providing the service
 - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

Submitting Claims

- Methods to submit:
 - Electronically through Web Portal
 - Electronically using Batch Vendor, Clearinghouse, or Billing Agent
 - Paper only when:
 - Pre-approved (consistently submits less than 5 per month)
 - Claims require attachments

ICD-10 Implementation

Claims with Dates of Service (DOS) on or before 9/30/15

Use ICD-9 codes

Claims with Dates of Service (DOS) on or after 10/1/2015

Use ICD-10 codes

Claims submitted with both ICD-9 and ICD-10 codes

Will be rejected

Providers Not Enrolled with EDI



COLORADO MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

Providers must be enrolled with EDI to:

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
 - Select Provider Application for EDI Enrollment

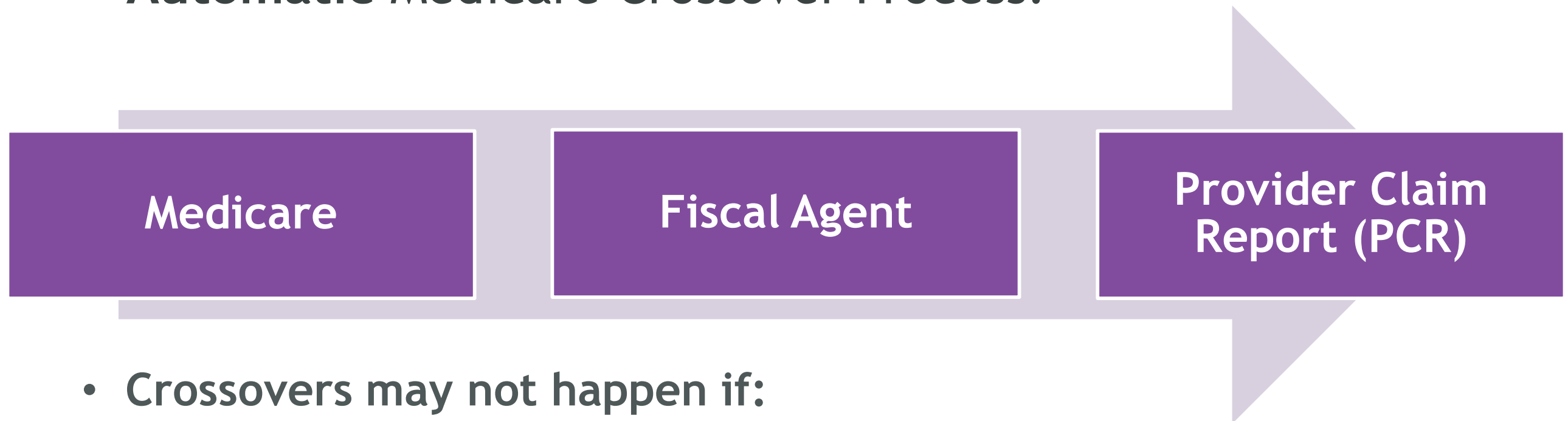
Colorado.gov/hcpf/EDI-Support



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Crossover Claims

Automatic Medicare Crossover Process:



- Crossovers may not happen if:
 - NPI not linked
 - Member is a retired railroad employee
 - Member has incorrect Medicare number on file

Crossover Claims

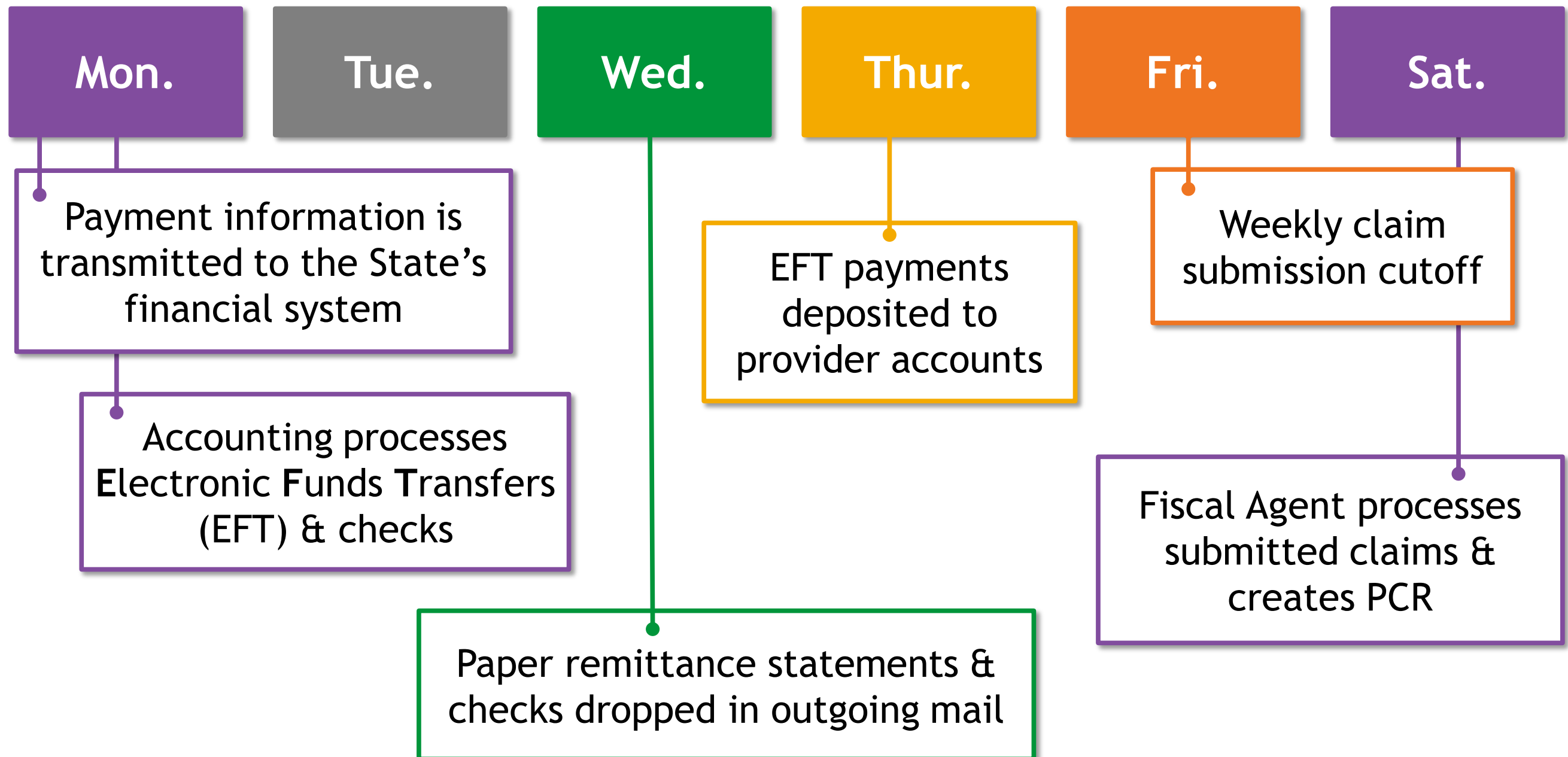
Provider Submitted Medicare Crossover Process:



- **Additional Information:**

- Submit claim yourself if Medicare crossover claim not on PCR within 30 days
- Crossovers may be submitted on paper or electronically
- Provider must submit copy of Standard Paper Remittance Advice (SPR) with paper claims
- Provider must retain SPR for audit purposes

Payment Processing Schedule



Electronic Funds Transfer (EFT)

Advantages

Free!

No postal service delays

Automatic deposits every Thursday

Safest, fastest & easiest way to receive payments

[Colorado.gov/hcpf/provider-forms](https://colorado.gov/hcpf/provider-forms) → Other Forms

PARs Reviewed by ColoradoPAR

- The ColoradoPAR Program reviews PARs for the following categories or services and supplies: diagnostic imaging, durable medical equipment, inpatient out-of-state admissions, medical services (including transplant and bariatric surgery), physical and occupational therapy, pediatric long term home health, private duty nursing, Synagis®, and vision
 - ColoradoPAR does not process PARs for dental, transportation, pharmacy, or behavioral health services covered by the Behavioral Health Organizations
 - Visit www.ColoradoPAR.com for more information

Website:

www.ColoradoPAR.com

Phone:

Phone: 1.888.801.9355

FAX: 1.866.940.4288

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via eQSuite®
- The ColoradoPAR Program will process PARs submitted by phone for:
 - emergent out-of-state
 - out-of area inpatient stays
 - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

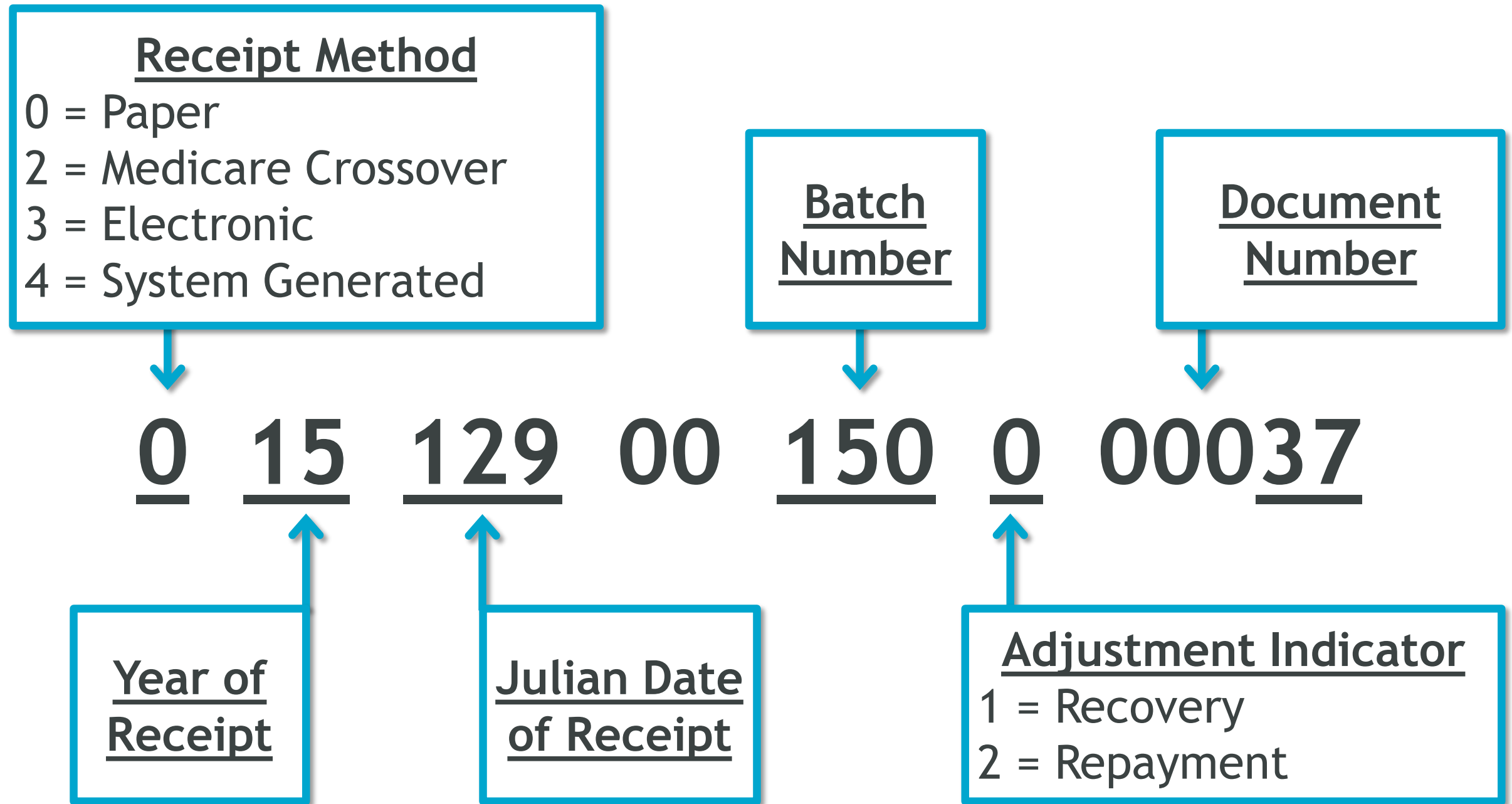
PAR Letters/Inquiries

- Final PAR determination letters are mailed to members and providers by the Department's fiscal agent
- Letter inquiries should be directed to the fiscal agent, not ColoradoPAR
- If a PAR Inquiry is performed and you cannot retrieve the information:
 - contact the fiscal agent
 - ensure you have the right PAR type
 - e.g. Medical PAR may have been requested but processed as a Supply PAR

PARs Reviewed by the Department

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is the ONLY number accepted when submitting claims
- **Long Term Care Nursing Facility PARs only**

Transaction Control Number



Timely Filing

- 120 days from Date of Service (DOS)
 - Determined by date of receipt, not postmark
 - PARs are not proof of timely filing
 - Certified mail is not proof of timely filing
 - Example - DOS January 1, 20XX:
 - Julian Date: 1
 - Add: 120
 - Julian Date = 121
 - Timely Filing = Day 121 (May 1st)

Timely Filing

From “through” DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

From DOS

FQHC Separately Billed and additional Services

Documentation for Timely Filing

- 60 days from date on:
 - Provider Claim Report (PCR) Denial
 - Rejected or Returned Claim
 - Use delay reason codes on 837I transaction
 - Keep supporting documentation
- Paper Claims
 - UB-04- enter Occurrence Code 53 and the date of the last adverse action

Timely Filing

Medicare/Medicaid Enrollees

Medicare pays claim

120 days from Medicare
payment date

Medicare denies claim

60 days from Medicare
denial date

Timely Filing Extensions

- Extensions may be allowed when:
 - Commercial insurance has yet to pay/deny
 - Delayed member eligibility notification
 - Delayed Eligibility Notification Form
 - Backdated eligibility
 - Load letter from county

Timely Filing Extensions

Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
 - File claim with Colorado Medicaid
 - Receive denial or rejection
 - Continue re-filing every 60 days until insurance information is available



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Timely Filing Extensions

Delayed Notification

- 60 days from eligibility notification date
 - Certification & Request for Timely Filing Extension - Delayed Eligibility Notification Form
 - Located in Forms section
 - Complete & retain for record of LBOD
- Bill electronically
 - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
 - Review past records
 - Request billing information from member

Timely Filing Extensions

Backdated Eligibility

- 120 days from date county enters eligibility into system
 - Report by obtaining State-authorized letter identifying:
 - County technician
 - Member name
 - Delayed or backdated
 - Date eligibility was updated

UB-04

Who completes the UB-04?

Inpatient
Hospital

Nursing
Facility

Home
Health/
PDN

Hospice

Dialysis
Centers

Residential
Treatment
Centers

Outpatient
Hospital

Outpatient
Lab

Rural
Health
Clinics

FQHC

Indian
Health
Services

Hospital-Based
Transportation

UB-04

UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs

Where can a Colorado Medical Assistance provider get the UB-04?

- Available through most office supply stores
- Sometimes provided by payers

UB-04 Certification



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Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ Date: _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Revised March 2015

**UB-04 certification
must be completed &
attached to all claims
submitted on the
paper UB-04**

**Print a copy of the
certification at:
[Colorado.gov/hcpf/
billing-manuals](http://Colorado.gov/hcpf/billing-manuals)**



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National Drug Codes (NDC)

- States must:
 - Collect rebates for physician administered drugs
 - Required by Deficit Reduction Act of 2005
 - Required for federal financial participation funds to be available for these drugs
 - Collect 11-digit NDC on all outpatient claims
 - For drugs administered during course of patient's clinic visit
 - NDC located on medication's packaging
 - Must be submitted in 5digit-4digit-2digit format

UB-04 Tips

Do

Submit multiple-page claims electronically

Do Not

- Submit “continuous” claims
- Add more lines on the form
 - Each claim form has set number of available billing lines
 - Billing lines in excess of designated number are not processed or acknowledged

Common Denial Reasons

Timely Filing

Claim was submitted more than 120 days without a LBOD

Duplicate Claim

A subsequent claim was submitted after a claim for the same service has already been paid

Bill Medicare or Other Insurance

Medicaid is always the “Payer of Last Resort” - Provider should bill all other appropriate carriers first

Common Denial Reasons

PAR not on file

No approved authorization on file for services that are being submitted

Total Charges invalid

Line item charges do not match the claim total

Type of Bill

Claim was submitted with an incorrect or invalid type of bill

Claims Process - Common Terms



Reject

Claim has primary data edits - not accepted by claims processing system



Denied

Claim processed & denied by claims processing system



Accept

Claim accepted by claims processing system



Paid

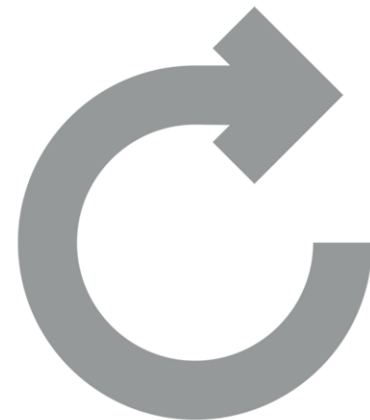
Claim processed & paid by claims processing system

Claims Process - Common Terms



Adjustment

Correcting
under/overpayments,
claims paid at zero &
claims history info



Rebill

Re-bill
previously
denied claim



Suspend

Claim must
be manually
reviewed before
adjudication



Void

“Cancelling” a
“paid” claim
(wait 48 hours
to rebill)

Adjusting Claims

- What is an adjustment?
 - Adjustments create a replacement claim
 - Two step process: Credit & Repayment

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

- Claim was denied
- Claim is in process
- Claim is suspended

Adjustment Methods



Web Portal

- Preferred method
- Easier to submit & track



Paper

- Complete Adjustment Transmittal form
- Be concise & clear

Provider Claim Reports (PCRs)

- Contains the following claims information:
 - Paid
 - Denied
 - Adjusted
 - Voided
 - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
 - Via Web Portal

Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
 - Fiscal agent will send encrypted email with copy of PCR attached
 - \$2.00/ page
 - Fiscal agent will mail copy of PCR via FedEx
 - Flat rate- \$2.61/ page for business address
 - \$2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

```

                                * CLAIMS PAID *
                                *****
INVOICE ----- CLIENT ----- TRANSACTION DATES OF SVC  TOTAL  ALLOWED  COPAY  AMT OTH  CLM PMT
NUM ----- NAME ----- STATE ID CONTROL NUMBER FROM TO  CHARGES  CHARGES  PAID  SOURCES  AMOUNT
7015      CLIENT, IMA      Z000000 04080000000000000001 040508 040508 132.00      69.46  2.00  0.00      69.46
PROC CODE - MODIFIER 99214 -                040508 040508 132.00      69.46  2.00
TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1      TOTAL PAYMENTS      69.46

```

Denied

```

                                * CLAIMS DENIED *
                                *****
INVOICE ----- CLIENT ----- TRANSACTION DATES OF SERVICE  TOTAL ---- DENIAL REASONS ----
NUM ----- NAME ----- STATE ID CONTROL NUMBER FROM TO  DENIED ---- ERROR CODES ----
STEDOTCCIOT      CLIENT, IMA      A000000 30800000000000000003 03/05/08 03/06/08 245.04      1348
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

```

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65' for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

Provider Claim Reports (PCRs)

Adjustments

Recovery

```

*****
* ADJUSTMENTS PAID *
*****
INVOICE --- CLIENT ----- TRANSACTION DATES OF SVC ADJ TOTAL ALLOWED COPAY AMT OTH CLM PMT
NUM ----- NAME ----- STATE ID CONTROL NUMBER FROM TO RSN CHARGES CHARGES PAID SOURCES AMOUNT
Z71 CLIENT, IMA A000000 40800000000100002 041008 041808 406 92.82- 92.82- 0.00 0.00 92.82-
PROC CODE - MOD T1019 - U1 041008 091808 92.82- 92.82-
Z71 CLIENT, IMA A000000 40800000000200002 041008 041808 406 114.24 114.24 0.00 0.00 114.24
PROC CODE - MOD T1019 - U1 041008 041808 114.24 114.24
NET IMPACT 21.42
    
```

Repayment

Net Impact

Voids

```

*****
* ADJUSTMENTS PAID *
*****
INVOICE - CLIENT ----- TRANSACTION DATES OF SVC ADJ TOTAL ALLOWED COPAY AMT OTH CLM PMT
NUM ----- NAME ----- STATE ID CONTROL NUMBER FROM TO RSN CHARGES CHARGES PAID SOURCES AMOUNT
A83 CLIENT, IMA Y000002 40800000000100009 040608 042008 212 642.60- 642.60- 0.00 0.00 642.60-
PROC CODE - MOD T1019 - U1 040608 042008 642.60- 642.60-
NET IMPACT 642.60-
    
```

Provider Services

Xerox
1-800-237-0757

Claims/Billing/Payment

Forms/Website

EDI

Updating existing provider profile

CGI
1-888-538-4275

Email helpdesk.HCG.central.us@cgi.com

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

Thank you!



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